

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003495	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/07/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT SETON SPECIALTY HOSPITAL LAFAYET	STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HARTFORD ST LAFAYETTE, IN 47904
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 33212 Facility Number: 003495</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey 9/7/2012</p> <p>Date of ISDH off site review - 9/11/2013</p> <p>Reviewer/Surveyor -Nancy Otten, RN, PHNS</p> <p>Based on review of the September 11, 2012 JCAHO Accreditation Survey Report, it has been determined that St. Vincent Seton Lafayette meets the requirements for Hospital Licensure in Indiana for 2012.</p>	S 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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